Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HEALTH SYSTEMS OF EAST TEXAS
PO BOX 1447
LUFKIN TX 75902-1447

Respondent Name
BITUMINOUS CASUALTY CORPORATION

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-0583-01

MFDR Date Received
October 18, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This has been denied as Ins states procedure code is only allowed once per claim. Attached are the Discharge summary report and the notes stating Adj Sue Reifel said it is ok to do another Eval."

Amount in Dispute: $104.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier denied reimbursement for this code because the provider did not use the proper code to describe the services that were actually performed. CPT code 97001 is utilized for the initial physical therapy visit, not for subsequent physical therapy visits. The provider performed and billed for the initial physical therapy on November 9, 2009. As such, the provider is not entitled to reimbursement for CPT Code 97001 for subsequent dates of service."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2010	Physical Therapy Evaluation 97001	$104.57	$104.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B5 – Pymnt Adj/Program guidelines not met or exceeded
   - R16 – Procedure code billing restricted/once per claim
   - GP – Service delivered under OP PT care plan
   - 193 – Original payment decision maintained
   - ORC – See Additional Information

Issues

1. Did the insurance carrier voluntarily certify the disputed service?
2. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The provider's position statement asserts that "Attached are the Discharge summary report and the notes stating Adj Sue Reifel said it is ok to do another Eval." 28 Texas Administrative Code §134.600(r) states, in pertinent part, that "The requestor and carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively… (2) The carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective review of medical necessity." The disputed service is not listed in subsections (p) or (q); therefore, pre-authorization was not required. However, the requestor has presented documentation to support that the provider sought voluntary certification. The requestor presented a memorandum of a phone conversation, created contemporaneously to the time the original phone call took place, in which the adjuster is purported to say "pt may have a PT Eval because it dosent required preauth." Per §134.600(c)(2), the carrier is liable for all reasonable and necessary medical costs relating to the health care "per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section." No documentation was found to support that payment was agreed upon prior to providing the disputed service. Therefore, the Division concludes that the insurance carrier did not voluntarily certify the disputed service.
2. The insurance carrier reduced or denied disputed services with reason codes B5 – "Pymnt Adj/Program guidelines not met or exceeded," and R16 – "Procedure code billing restricted/once per claim." The respondent's position statement asserts "The carrier denied reimbursement for this code because the provider did not use the proper code to describe the services that were actually performed. CPT code 97001 is utilized for the initial physical therapy visit, not for subsequent physical therapy visits. The provider performed and billed for the initial physical therapy on November 9, 2009." The respondent further presented a memorandum from Corvel Corp., the insurance carrier's audit company that processed the disputed bill, which asserts that "Per the definition of CPT code 97001, this is billed when the provider performs an initial Physical Therapy Evaluation on the patient for a specific claim and date of injury." Review of the submitted information finds no documentation of payment adjustment/program guidelines to support the denial of CPT code 97001. The respondent did not submit documentation of Medicare, AMA or Division policies to support that CPT code 97001 is restricted to billing only once per claim. The respondent did not present an explanation of benefits or other sufficient documentation to support that CPT code 97001 had been previously paid. Nor did the respondent support that CPT code 97001 had been paid to the requestor. Or that a previous physical therapy evaluation was performed in relation to the same claim or injury. The Division therefore concludes that the respondent has not supported the above denial reason codes. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.
3. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
4. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.
5. Under the Medicare Outpatient Prospective Payment System (OPPS), procedure code 97001 has a status

indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services §134.203(c). The fee listed for this code in the applicable Medicare fee schedule is $69.25. This amount divided by the Medicare conversion factor of 36.0791 and multiplied by the Division conversion factor of $54.32 yields a reimbursement amount of $104.26.

6. The total recommended payment for the services in dispute is $104.26. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $104.26.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $104.26.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $104.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	May 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.